



listening to patients,
speaking up for change

“I thank the Patients Association for the pressure they put on us to keep improving standards. Long may they continue.”

Sir Ian Carruthers, when Acting Chief Executive of the NHS (May 2006)



Patients Association

Infection Control – Is it only skin deep?

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6th November 2006

Infection Control – Is it only skin deep?

Call to Action

The Patients Association calls on the Government to reinforce its own legal code under the Health Act October 2006 immediately, if its target to reduce HCAs by 50% by 2008 is to be met.

- The NHS cannot afford the waste caused by Health Care Acquired Infections (HCAs) – wasted money, wasted patient recovery time, wasted professional time caring for patients and bed blocking
- Infection Control budgets must be ring-fenced
- Assessments must be made of the impact on appointments kept and the clinical outcomes of patients' anxiety about infection
- Cost-cutting decisions must not be made at the risk of patient safety
- Advice from the Department of Health needs to be simplified and streamlined to ensure maximum compliance with best practice.

The Patients Association

FOREWORD BY CLAIRE RAYNER,
PRESIDENT OF THE PATIENTS ASSOCIATION



A handwritten signature in blue ink, appearing to read 'Claire Rayner', with a stylized flourish at the end.

The Patients Association was set up over 40 years ago to give a voice to patients using U.K. healthcare. Many campaigns have come and gone over that time, but one above all stands out – our fight against hospital acquired infections. Nothing causes more anguish or fear for patients. Nothing else has the same potential to undermine all the wonderful work that goes on day in and day out in our health services.

Since 2005, when our first Clean Hospitals Summit brought together clinicians, managers and providers of solutions to this most basic of problems, we have been delighted to see so many in the health service join our campaign. We launched the 100 day challenge later that year to campaign for greater patient safety in infection control.

Today, I am delighted to welcome you to the launch of our latest Survey: **INFECTION CONTROL – IS IT ONLY SKIN DEEP?** Surveys like this compare the reality to the rhetoric, something the Patients Association applauds' as it continues to do in a

number of areas. By surveying the people on the frontline of infection control what that reality is, the Patients Association can play its part in this crucial campaign on behalf of patients everywhere. An informed patient is a safer patient.

We are grateful to Paul Keetch, MP for so kindly sponsoring this Reception and to Enturia for its educational grant in making this Survey, and an excellent tea, possible.

Infection Control – Is it only skin deep?

Programme

- 16.00 Registration and coffee
- 16.15 **Paul Keetch MP**
- 16.20 **Welcome and introduction**
Claire Rayner
President of The Patients Association
- 16.30 – 17.00 **Presentation of infection control survey**
Vanessa Bourne
Head of Special Projects
The Patients Association
- 17.00 – 17.15 **Dr. Angela Galloway**
Consultant Microbiologist
The role of the Microbiologist and the difficulties facing the profession from an Infection Control point of view
- 17.15 – 17.30 **Sheila Morgan**
Infection Control Nurse
Infection control from an Infection Control Nurses point of view
- 17.30 – 17.50 **Questions**
- 17.50 – 18.00 **Close of event**
Claire Rayner
President of The Patients Association

Ten top tips to using your patient power!

The Patients Association has always maintained that patients can play their full part as members of the team looking after them. So to help patients pull their weight, whether they are admitted to hospital as emergencies or are called in from the waiting list for elective care, usually surgery, we have prepared a ten-point guide. Each patient can pick off the list the things they are able to do and ignore the rest.

- 1** Check your Trust's Annual Health check ratings October 2006. Log on to www.healthcarecommission.org.uk and follow the appropriate links. The ratings are made up of a number of performance indicators and show how Trusts are doing in relation to some of the main targets set by the Government for the NHS.
 - 2** Before a planned admission take a long hot soapy bath or shower, without using heavily scented brands, and have an all-over scrub with a soft gentle brush or loofah. Clip your toe and finger nails (removing all nail polish) and wash your hair. Put on freshly laundered underwear. All this helps prevent unwanted bacteria coming into hospital with you and complicating your care.
 - 3** When preparing the items you are taking with you, such as newly-washed nightwear, dressing gown, slippers and so on, add packs of antiseptic hand-wipes together with a couple of bulldog clips (from most stationers) and some plastic bags. Use the wipes every time you go to the loo, and also before and after meals. Use a bulldog clip to clip an open bag to the edge of the bottom sheet and use it for your own rubbish. Give full bags to the ward cleaner for disposal.
 - 4** When you arrive take a note of areas that are messy or dirty and point them out to staff. A clean and tidy environment not only keeps infection at bay, it looks better, makes all patients feel better and can get you out of hospital faster.
 - 5** Arrange a "phone tree" with family and friends. Ask one of them to be the person who phones the ward staff for information on how you're getting on, and then to pass the news on to everyone else (e-mail a good for this!). This will obviously save a lot of busy staff time.
 - 6** Ask visitors to co-ordinate their visits so there are only two people at the bedside at any time. The more visitors a patient has the higher the risk of bringing in an infection from outside. Also, instead of coming straight from work try to persuade them to go home and have a thorough shower or bath before coming to see you – again reduces the risk of bringing infection in from outside.
 - 7** Ask them all to use the hand cleaners that should be at the foot of each bed (as specified by the Government) as they arrive and before they leave. This can greatly help in the fight against the spread of infection.
 - 8** Try not to let any children be brought in as visitors. However much you want to see them it's better not to expose them to possible hospital infections nor to bring their own coughs and colds in.
 - 9** Tell visitors not to sit on your bed. Not only uncomfortable for you, but another way to prevent infection reaching you. Remember even healthy people carry bacteria on their skin; indeed, we all do! And if they have even the slightest snuffle or indication of a cough ask them nicely not to come and see you.
 - 10** Don't be afraid to ask a nurse or a doctor – even if a specialist – who comes to your bed to touch you, for example to examine a wound or check you in some way, whether they have washed their hands or used the disinfecting hand gel.
- Above all, never be afraid to ask questions, especially about your own condition or to make valid complaints.** It may be easiest to speak to whoever is in charge of the ward. Your awareness of your own condition will help you to recover more quickly and your complaints or comments on what happens in the ward could be of great value.

Introducing our speakers



Vanessa Bourne
Head of Special Projects
Patients Association

Vanessa has been a supporter of the Patients Association since 1995 first as Vice Chairman and from 1999-2002 as Chairman. She is a former chair of FHSAs and Health Authorities in west Wales. She is also a former Chairman of the Welsh Association of Health Authorities and Trusts, elected by colleagues.

She has been a member of the ethics committee of Dr. Foster and the Patients Council of NICE. She is a Trustee of Leonard Cheshire (Vice Chairman of the International Committee and Chairman of Wales and the West Midlands region).

She is now Head of Special Projects at the Patients Association.



Claire Rayner
President
Patients Association

Claire trained as a nurse, winning the gold medal for outstanding achievement when she became an SRN in 1954. She also studied midwifery at Guy's Hospital, worked at The Royal Free Hospital and as a Paediatric Sister at Whittington Hospital.

Since the start of her writing career in 1960, she has written over 90 books, both fiction and non-fiction, the latter covering such topics as home nursing, family health, sex education, baby and childcare.

Probably best known as the UK's leading "Agony Aunt" Claire has written problem pages for teenage magazines as well as national newspapers. As a medical journalist she had her own columns in various women's magazines and her work frequently appears in professional journals. She has had her own programmes on TV and radio and is often heard as a commentator on health matters.

She was for several years a member of the Royal College of Nursing Committee on Ethics. She was a non-executive director of Northwick Park and St Mark's NHS Hospital Trust for six years and is Patron/advisor/ supporter of many welfare, social and charitable organisations including Charter 88. She is also frequently invited to sit on government groups and committees including The Royal Commission on the Long-term Care of the Elderly and the Patients' Charter Group.



Dr Angela Galloway

Consultant Medical
Microbiologist and Head of
Microbiology

Newcastle upon Tyne Hospitals
NHS Foundation Trust.

She qualified from the Royal Free Hospital School of Medicine, London in 1978 and subsequently specialised in Microbiology, training in Liverpool. She was first appointed as a Consultant Medical Microbiologist in 1984 in St. Helens and Knowsley, Merseyside and subsequently moved to the North East taking up a Consultant post in Durham in 1988. She was appointed as a Consultant to the Public Health Laboratory Service (PHLS) in Newcastle in 1996 and subsequently transferred to the Newcastle Hospitals Trust. Her main interest is in infection in immunocompromised patients, especially bone marrow transplantation. She is Chair of the Microbiology Committee for the Association of Clinical Pathologists and Regional Specialty Advisor for the Royal College of Pathologists.



Sheila Morgan

Nurse Consultant Infection
Control;

Newcastle upon Tyne Hospitals
NHS Foundation Trust.

Trained at St Thomas' Hospital, London and gained postgraduate experience in a variety of specialties including intensive care, cardiothoracic surgery, liver transplantation, neurosciences and acute medicine/surgery in major teaching hospitals. Sheila also co-ordinated the patient programme for a Medical Research Council European Multi-Centre Study whilst working in a regional oncology/radiotherapy unit.

In 1991, Sheila was appointed by Freeman Hospital (NHS Trust) to develop and manage a trust-wide surveillance system for detecting hospital-acquired infections, previously piloted in the hospital, and to explore post-discharge surveillance methods – the former becoming an integral part of the infection control programme in the Trust

In 1993, Sheila was appointed as a Clinical Nurse Specialist in Infection Control at the Freeman Hospital in Newcastle.

In January 2002, Sheila was appointed to her current post in the Newcastle Hospitals Trust and has infection control lead for Health Care Associated Infection Surveillance, Decontamination and Audit.

From November 2000 to November 2002, Sheila was Chair of the Infection Control Nurses' Association (ICNA).



Paul Keetch

MP

Liberal Democrats

Paul Keetch was first elected to Parliament as the MP for Hereford on 1 May 1997. Re-elected in 2001 and again in 2005, Paul has entered the record books as a Liberal Democrat holding the Hereford seat for a third consecutive term. Upon entering Parliament Paul gained experience as a member of the Liberal Democrat Health team, followed by a period as the Liberal Democrat Employment and Training spokesman. As a member of the Commons Employment Select Committee, Paul frequently cross-examined Ministers on employment issues such as New Deal, Part-time working and Pathways into Work for Women.

Paul has always had a keen interest in defence and in 1999 moved to the position of Defence spokesman being promoted to Shadow Defence Secretary shortly afterwards.

As a member of the Liberal Democrat Foreign Affairs and Defence team, headed up by the Rt Hon Sir Menzies Campbell MP, Paul was influential in defence debates and the stance the Liberal Democrats took on the controversial Iraq war. He has worked closely with contacts in the Armed Forces, the Ministry of Defence and the defence industry. He is well known for supporting the rights of members of the Armed Forces in Parliament and for pressing for reform.

In July 2005 Paul was officially appointed to the prestigious Foreign Affairs Select Committee where he joins fellow Members of Parliament in scrutiny of matters relating to foreign affairs in Parliament.

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About the Patients Association

Listening to Patients, Speaking up for change

The Patients Association was established to develop better and more responsive health services for patients, through listenings to the concerns of patients and focusing its work on what matters to them.

We advocate greater and equitable access to high quality care, accurate and independent information for patients, and patient involvement in decision-making as a right.

Our Interest in Infection Control

This survey is the latest Report in the Association's continuing campaign in the field of infection control and patient safety, work we have undertaken on a rolling programme since 2000.

Our first report, *"Hospital Acquired Infection and the Reuse of Medical Devices"* in 2000, attracted major publicity and led to significant new policy and investment by the Department of Health. The 2001 report was entitled *"The Decontamination of Surgical Instruments: A Survey of Hospital Staff in the UK"*, and was designed to assess progress since the implementation of Health Service Circular 2000/032.

One of our reports in 2002, was based on a survey of the new Strategic Health Authorities to assess how much they would be following the decontamination and medical device issue under the new local agenda and *"Shifting the Balance of Power"* (October 2002).

This report was the result of a collaboration between The Patients Association and three of the most important professional groups within the field of NHS infection control and sterile services – The Infection Control Nurses Association (ICNA), The Institute of Sterile Services Management (ISSM) and The National Association of Theatre Nurses (NATN). The survey was directed at the new Strategic Health Authorities (SHAs) to try and find out how much they were monitoring the issue of decontamination within the Trusts in their area. This was in accordance with the principles set out in *"Shifting the Balance of Power"*.

In October 2004 we conducted a survey among healthcare professionals which revealed five percent of those questioned did not clean their instruments

between patients; more than half re-used sterilising fluid; many endoscopes never made it to the Central Sterile Department at the end of each clinic; and there were no uniform guidelines on who is responsible, or just what they should do.

The *"Infection Control and Medical Devices"* survey by the Patients Association on 2004 showed that 35 percent of those questioned had never heard of the Chief Medical Officer's 2003 report *"Winning Ways"*, which identified intensified control measures as essential to defeat healthcare associated infection.

Unsurprisingly, the survey also revealed that patients were not informed about infection control measures and 68 percent of respondents said that patients were not told what measures were taken to keep medical instruments clean.

The Patients Association survey was conducted among NHS trusts' infection control staff, consultant microbiologists, senior clinical nurses, consultant gastroenterologists, decontamination managers, Central Sterile Services Department managers, risk managers, charge nurses, and theatre managers and staff in endoscopy units throughout the UK.

In March 2005 we published another report, this time in collaboration with the Institute of Decontamination Sciences (IDSc), formerly the Institute of Sterile Services Management (ISSM), the Infection Control Nurses Association (ICNA) and the National Association of Theatre Nurses (NATN). The report, *"Tracking Medical Devices and the Implications for Patient Safety- A survey of hospital practices and opinions"*, established that there is near universal agreement (97%) that where there is a move to Super Centres taking over medical device decontamination, there will need to be an infrastructure in place to allow individual devices to be returned to the hospital from which they originated. Only then can a full history of their usage and location be maintained.

The purpose and timing of the report was to shed light on the key patient safety issues of medical device management. This came at a time when fundamental decisions were being made about the future management of medical devices under the Super Centre investment programme. This programme will transform the way medical devices are managed in the NHS, with some Trusts collaborating to create super centres facilities to deal with large volumes of medical

device decontamination off-site. Not all Trusts will embark on Super Centres, leaving a mixed provision of decontamination facilities

The report revealed that almost a quarter (24%) of respondents disagreed or strongly disagreed with the statement that they were confident that medical devices were decontaminated to an appropriate level of cleanliness for theatre use. This must be a cause for concern.

As a result of these reports, and particularly from the public concerns of many patients, The Patients Association initiated *The Clean Hospital Summit*. The first Summit of its kind, held in April 2005 started as a consequence of the volume of concern amongst patients about the need to address the real problem of healthcare associated infections. A great deal of knowledge and expertise was brought together to help healthcare facilities across the country improve safety of patients and, through learning from each other, introducing new technology and good practice reduce the number of patients acquiring, and often dying, from an infection in hospital.

The Summit was followed later in November by the “100 Day Challenge Report” on action taken within the NHS as a direct result of the Summit’s findings.

Earlier in 2006 we organised a further event “*Cleaner Hospitals, Safer Healthcare*” to build on the Summit, expanding the range of topics covered, and initiated the first Patients Association Awards scheme.

The Methodology of Infection Control - Is it only skin deep?

This joint postal and web-based questionnaire was sent in August 2006 to a random sample of 500 NHS members of staff, all of whom had a degree of involvement in the delivery of infection control practice, whether through clinical interface with patients, managerial responsibility or tasked with procurement. With this broad range of audiences in mind, the survey was divided into two sections – Clinical and Organisational, allowing both clinical and non-clinical professionals an opportunity to focus on the areas which resonate the most.

The questionnaire was initially sent in a paper format. Later, a reminder email was sent with a link to an on-line questionnaire hosted by The Patients Association.

The survey closed on 22nd September.

Responses

We received and analysed a total of 169 questionnaires from a cohort of 500, giving us an excellent return rate of 33.8%. All responses to the questions in this report are represented as a percentage of those who answered the question, which in many cases is marginally less than the number of questionnaires returned.

The vast majority of responses were from infection control nurses (34%) and directors of nursing (53%). Many other specialties contributed, including cardiac surgeons, medical directors and consultant microbiologists.

As you will see from the report, we also prompted respondents to provide ‘qualitative’ comments which add colour to their responses. These comments can be found in the Executive Summary, the results of the report and in the appendices.

Executive summary

- Overwhelmingly (93.4%) survey respondents had to reassure their patients worried about catching HCAs while in hospital. Additional time was needed for this, reducing actual caring time.

“Some patients have decided not to have procedures performed”

- Nearly half (44%) of respondents said that not all staff were adequately trained in infection control practice. 27% said that infection control leaders were not in post at every level of their organisation.

“Financial situation of Trust: unable to fund training and delivery”

- 87% believed they were adhering to best practice, but worryingly 13% admitted that they were not. While the majority of respondents (86%) stated they had adequate access to training and development, there was insufficient time to read all the information they received.

“Time is limited due to lack of money, resources and concentration on targets”

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- 49% said that there was no dedicated “ring-fenced” budget for infection control teams within their hospital.

“The infection control team spends time and effort which could be used caring for patients looking for sponsorship/funding to run much needed training programmes”

- “Hands” was cited as the main cause of HCAI transmission by 77% of respondents. But there was uncertainty among them as to the ranking of other causes, with “surgical wounds” ranking between “most important” and “least important”.

“Patients, visitors, relatives need to be made aware that they also have a role. It is very disheartening when we have procedures in place and take staff to task, to have the public ignore them.”

- 73% of respondents felt that procurement decisions were not always made by an appropriately trained professional. Only 27% felt that an appropriate professional always made the procurement decisions within their trust.

“Multi disciplinary decision including pharmacists – too many people involved”

- On cutaneous/skin best practice assessment, 35% had continual assessment, 13% on an annual basis, and 7% admitted they never assessed best practice.

- On the rationale for purchase of skin preparations, 57% cited clinical effectiveness and 33% current guidelines (“EPIC” 2001, “Saving Lives” 2005, “Going further faster” 2006).

“product evaluation group”

- When asked which skin preparation was used for which procedure, Chlorhexidine-based solutions accounted for over 38% of cases. However, although evidence-based, there was a delay in the availability of 2% Chlorhexidine-based solutions in the UK.

- Some procedures such as percutaneous-site insertion and blood gas collection predominantly used alcohol only to prepare the skin.

“It is important to remember that alcohol needs time to dry and antiseptic contact time is very important”

- 88% of respondents were either “satisfied” or “very satisfied” with their infection control practices. 10% were “dissatisfied” and 2% “did not know”!

“We have very high levels of bed occupancy (99%) which means we are at high risk”

“Infection control is not particularly high on this Trust’s agenda. The Saving Lives campaign has gone some way to improving this”

- Trusts are required to collect infection data on MRSA, surgical site infection and Clostridium difficile.
- However, only 21% of respondents confirmed collection of surgical site data and only 27% Clostridium difficile.

The Patients Association notes that the worrying and haphazard situation revealed by this report continues to exist despite a plethora of guidance from the Department of Health, investigations by the Public Accounts Committee and the Healthcare Commission’s annual Health Check.

The Patients Association notes the Health Minister’s assurance of 24th July 2006 that the Government and the healthcare commission “will not shy away from using the powers in the Health Act to ensure that trusts do everything possible to eradicate avoidable infection.”

REPORT

Question 1: Which of the following best describes your role/title?

The survey was deliberately aimed at a wide cross-section of the NHS, reflecting how many professions are now involved in infection control practice within frontline NHS organisations.

It is not surprising that the vast majority of responses worked in clinical positions. Facilities managers (12%) formed the majority of the non-clinical respondents. Despite invitations, no procurement managers responded.

1. Role/job title?

Choice	Total	%
Anaesthetist	2	1
Infection Control Nurse	65	38
Modern Matron	7	4
Facilities Manager	20	12
Purchasing Manager	0	0
Theatre Nurse	1	0
Vascular Nurse	4	2
Other*	70	43
Total	169	100

* Included Directors of Nursing, Nurse Executives, Medical Directors and surgeons.

Question 2: Which do you think presents the higher risk of HCAs to patients?

This question stimulated a worryingly wide range of answers. Despite clear guidance from the Department (*Saving Lives-2005*), respondents' prioritisation of risk was varied. Given the clinical need to be aware of the highest risks to patients contracting HCAs, it was concerning to see such a varied response with the skin i.e. surgical sites, hands and catheters all being seen as the highest priority.

However, the greatest confusion occurred when asked to prioritise the remaining areas. Surgical site infection, a significant risk to patients, ranged from

highest priority to the lowest priority as did catheters. There was no direct correlation within the answers.

This raises a number of pertinent questions. How do staff prevent a problem occurring if they are unaware of the highest risk? If they are following Department of Health guidelines that assess degrees of risk, why was this not evident in these results?

2. Highest risk of HCAs to patients?

Choice	Priority 1	Priority 2	Priority 3	Priority 4	Priority 5
The skin (e.g. wound areas)	6	27	30	24	13
Hands	124	10	7	1	1
Catheters (e.g. urinary and venous)	31	48	17	10	2
Equipment (e.g. ventilators)	0	8	26	34	26
Surfaces in areas such as wards	0	5	12	24	49
	161	98	92	93	91

Question 3: What influences the purchasing decisions for cutaneous skin antiseptic (prep) products in your hospital/trust (i.e. products aimed at cleaning the skin prior to procedures being undertaken)?

It was reassuring to see that the majority of those who responded felt that best practice guidelines such as *"Going further faster"*, *"Saving Lives"* and the *"EPIC project guidelines" 2001*, were the most significant reason for purchasing decisions.

The importance of the actual cost of products highlights the need to guard against short-term financial cuts at the expense of long-term benefits.

3. What influences c/s antiseptics (prep) purchase?

Choice	Priority 1	Priority 2	Priority 3	Priority 4	Priority 5	Priority 6
Influence from senior colleagues	6	8	15	31	35	40
Clinical effectiveness of product	77	49	4	4	7	4
Published guidelines such as 'Saving Lives' and best practice	47	46	13	10	8	10
Value for money	7	26	49	30	22	3
Actual cost	4	9	25	35	33	26
Historical use – "tried and tested"	8	8	30	19	17	53
	149	146	136	129	122	136

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Question 4: Who makes the final decision to purchase cutaneous/skin antiseptic (prep) products within your trust?

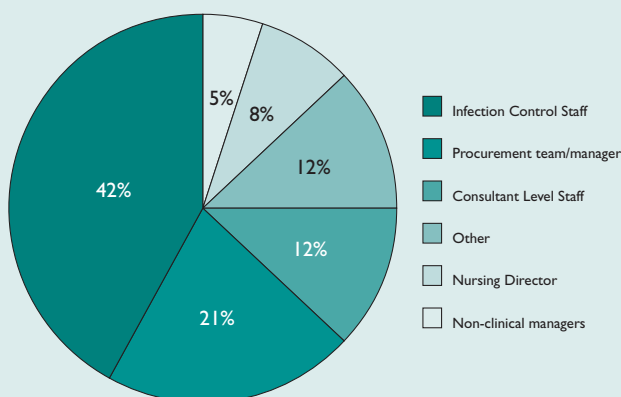
The majority cited infection control staff as the key decision makers when deciding to purchase skin preparation products within their trusts. This is in line with Department of Health's "Saving Lives" document and "Going further faster" guidance.

We believe that the best policy is for the decision to be made by the professional with the best knowledge base, away from the pressures to constantly look for the cheapest option that just meets the need.

This raises the question of non-clinical influence on clinical/safety decisions.

However, in line with the influence short-term costs have on clinical practice in the NHS, our respondents have stated that procurement managers have an integral part to play in the final decision to purchase the clinical preparation. Yet many, if not the majority of them, will not have had any clinical experience. The questions that remain are whether procurement managers when deciding to purchase a product have any knowledge of recommended best clinical practice and have an understanding of the impact that their decision could have on patients' lives.

4. Decision to purchase c/s antiseptic (prep)?



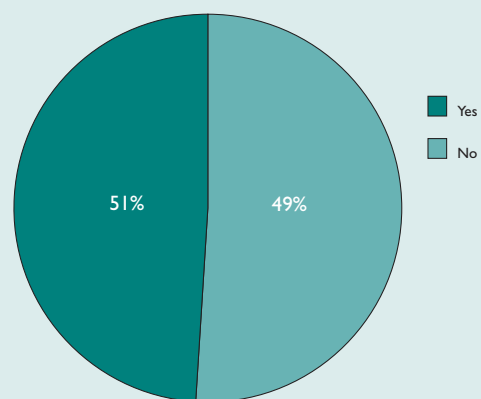
Question 5a: Does your trust operate with a ring-fenced/dedicated budget for infection control i.e. allocated funds?

At a time when financial deficits are requiring ad hoc cuts in budgets, it is cause for concern to see that 50% of respondents are potentially at risk because they are not ring-fenced.

This financial support of infection control practice is a priority in the *Health Act 2006 - Code of Practice for the Prevention and Control of Healthcare Acquired Infections*. It states that each NHS body must have "mechanisms by which the Board intends to ensure that adequate resources are available to secure effective prevention and control of healthcare association infections."

Whilst we recognise the Department of Health and the Health Protection Agency (HPA) have prioritised reducing the burden of HCAs in the NHS, the ability to do so relies heavily on giving staff the resources to provide best-practice in the workplace. The fact that many NHS organisations do operate with a dedicated budget raises the issue why not all?

5a. Ring-fenced/dedicated budget for infection control?



Question 5b: If no, does this impact on the trust's practice? If so, how?

"Limited dedicated time available to address influencing procurement and purchasing"

"Very limited funds"

"The infection control team spends time and effort (could be used elsewhere) looking for sponsorship/funding to run much-needed training programmes"

"No money can be released for infection control projects by the Director of Infection Prevention Control"

"No funds available. Always have to look for elsewhere"

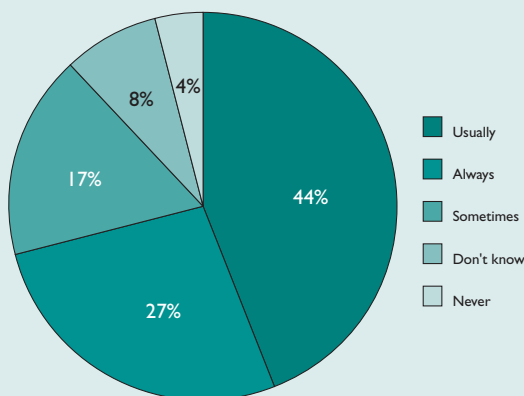
"Limits training and resources. Limits IT support"

Question 6: Are purchasing, decisions for cutaneous/skin antiseptic (prep) products influenced by the appropriate clinician?

Only 27% confirmed that the appropriate clinician always made this decision.

Given the clear guidance, from the Department of Health this causes concern. While 44% of decisions were "usually made appropriately" the *sometimes, never and don't know*s combined were greater than *always*.

6. Purchasing decision made by appropriate clinician?

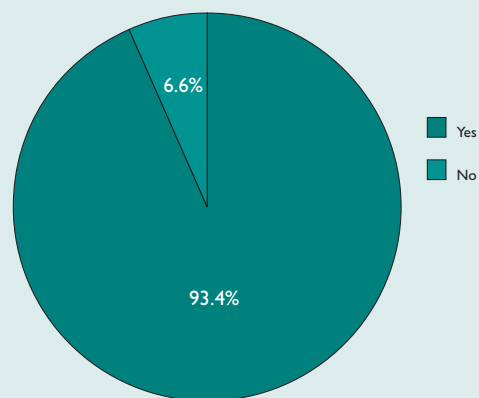


Question 7: Have your patients experienced anxiety due to the possibility of catching a HCAI?

Of all the questions and responses in this survey, this question provides the clearest evidence of the struggle professionals face on the front line. 93% agreed that patients do experience anxiety and 7% said no.

The Patients Association recommends that work be undertaken to assess the impact on appointments that are not kept and on clinical outcomes as a result of such anxiety.

7. Patient anxiety?



CLINICAL

Question 8. On average, how often is the effectiveness of cutaneous/skin antiseptic (prep) assessed?

35% of those taking part felt that skin preparations were assessed on a continuous basis, but they were in the minority. The majority of answers given stated that assessment took place between three months and never. An unsettling number of respondents did not know how often this practice was assessed.

There have been a number of clinical studies conducted over the past few years assessing the dangers of using chemicals such as Chlorhexidine and iodine too much in the prevention of infection, a practice that can result in bacteria becoming immune to the cleansing agent. So whilst it may not be possible to constantly assess the clinical practice on a continuum, it is clearly undertaken in some Trusts and not in others.

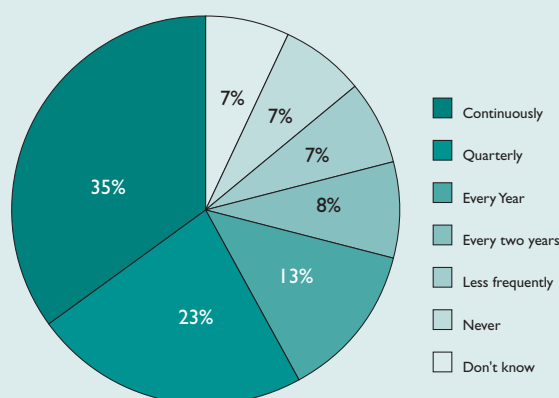
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While infection control practices and prevention techniques are constantly evolving, any Trust that does not assess its practice on a regular basis must be at risk of not conforming to recent best practice, therefore putting patients at risk of infection and possible serious complications.

The results published by the Healthcare Commission as part of its Annual Health Check states that “MRSA targets still need vigorous action” There is a public commitment to halve the MRSA infection rate by March 2008. The reduction over the last year (from 2004/2005 to 2005/2006) was 2% nationally.

8. Effectiveness of c/s antiseptic (prep) assessed?



Question 9: Which of the following influence the clinical decision to recommend a certain cutaneous/skin antiseptic (prep) products for use in your hospital/trust?

Whilst earlier survey questions asked why a decision to purchase a product was made, this question focuses on the key drivers in recommending that product for use.

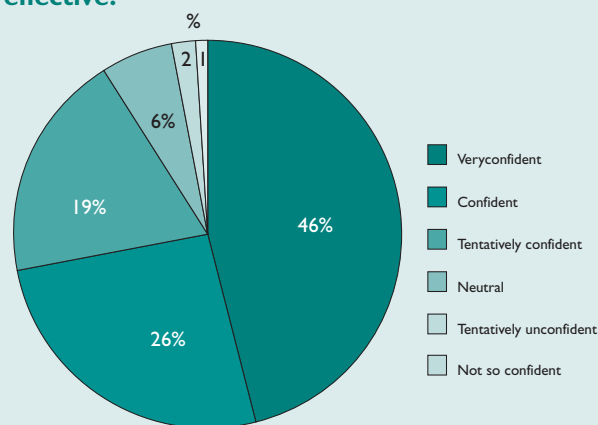
At the heart of the decision making process should be a clinical decision to recommend a certain treatment or practice for adoption in the Trust. The answers to this question clearly show that, in the main, clinical decisions plays the biggest part in deciding practices to be used in the future.

Choice	Priority 1	Priority 2	Priority 3	Priority 4	Priority 5	Priority 6
Influence from senior colleagues	4	8	22	19	29	20
Clinical effectiveness of product	64	36	3	4	2	1
Published guidelines such as 'Saving Lives' and best practice	37	40	10	9	3	3
Value for money	3	15	43	22	19	3
Actual cost	1	6	13	29	36	19
Historical use – “tried and tested”	4	3	14	17	14	49
Total	113	108	105	100	103	95

Question 10a: How confident are you that the cutaneous/skin antiseptics (prep) you use are the most effective at protecting patients?

Given the responses to Q. 8, these answers need to be read with caution. If respondents feel that they are using the most effective practice, but never check to see if there is anything better out there, they could well be working outside of best practice but would not know.

10. Confident that c/s antiseptic (prep) you use effective?



It is certainly the case that in the UK, the vast majority of skin preparations are either formulated on 0.5% chlorhexidine gluconate (CHG) or iodine based solutions. A number of studies undertaken by the US Food and Drugs Administration (FDA) recommended the use of 2% CHG solutions for the preparation of skin prior to procedures being undertaken. The Health Protection Agency recommends the use of 2% CHG for use in skin preparations within the NHS. The “EPIC project guidelines” also confirm that 2% CHG should be seen as best practice in skin preparation.

However, the vast majority of skin preparations are either formulated on 0.5% Chlorhexidine gluconate (CHG) or iodine-based solutions.

Given some of the comments that have been made, we can surmise that many respondents are confident that their current practice is safe, while recognising that more effective products may be available. While it is important staff feel confident in the preparations they are using, it is clear that many may not be following best practice.

Question 10b: What are the reasons for your choice?

“Consideration is always given to cost”

“Clinical staff make the decisions – well known brands used”

“Regular audits carried out”

“Evidence based but delayed availability of 2% Chlorhexidine in this Country”

“Research demonstrates it to be most effective of those available in the UK”

“Some clinicians still prefer Betadene”

“Influenced and dependent on practitioner use”

“Efficacy, if there is more than one choice, ethical preferences and cost”

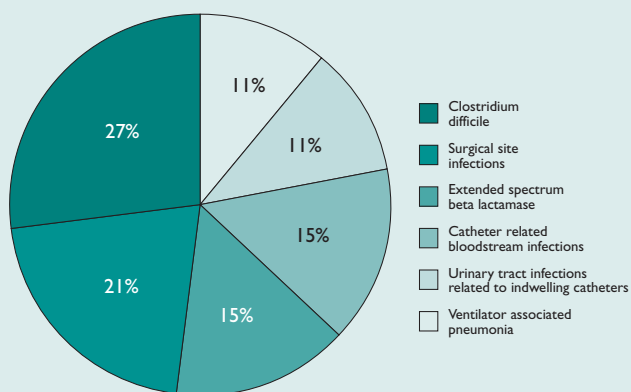
“We carry out our own tests to ensure that the product is effective”

Question 11: Aside from MRSA, does your Trust/PCT collect data on the incidence of the following HCAIs? If yes, does your trust use this data to increase the quality of patient care?

In the Chief Medical Officer’s report “Winning Ways” (2003), it was made clear that all Trusts had an obligation to produce an annual report detailing the level of healthcare acquired infections in their organisation. This has been reinforced by the recent “Health Act 2006– Code of Practice for the Prevention and Control of Health Care Acquired Infections”. The new powers in the Health Act will be used to deal with organisations that consistently fail to follow the good practice set out in the Code of Practice for the Prevention and Control of Healthcare Associated Infection (HCAI). Trusts were given a two month

period to adjust to the requirements of the Code and from then on improvement notices may be served on those who fail to implement it effectively.

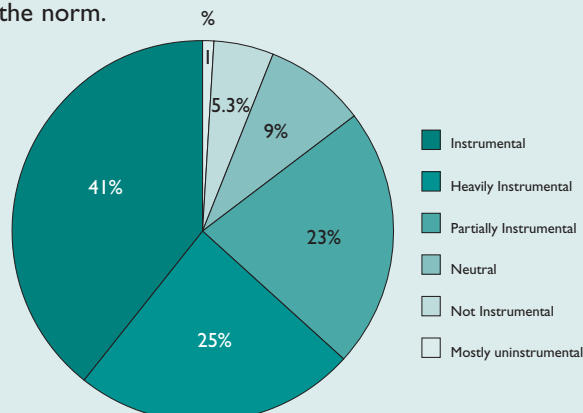
11(a). Collect data on following HCAI’s?



In the light of continuing guidance, most notably “Winning Ways” 2003 and the legally enforceable Code in the Health Act 2006, it is surprising that there is uneven collection of infection data.

Question 12: To what extent is senior management instrumental in measures to control infection in your department?

As can be seen from the data, senior management is predominantly instrumental in controlling infection within the clinical environment. Given the call by the Department of Health for every NHS body to designate a Director of Infection Prevention and Control accountable directly to the Board (Code of Practice), it is important to see that senior management are heavily involved in the development of practice in their working environment. As with any involvement, if senior management do not lead from the top, it is unlikely common practice will become the norm.



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Question 13: How much do you agree with the following statements?

(a) Infection control leaders have been appointed at every level of the organisation.

Whilst a large percentage (**70%**) stated that their Trusts have infection control leaders at every level of the organisation, a **worrying 39% did not**.

Although the vast majority of NHS organisations meet the Government’s policy of a named Director of Infection Prevention and Control, it is clear that this top-level approach is not filtering through to all areas in many Trusts. Whilst we cannot say whether this affects patient care, it is certainly a very worrying statistic.

b) Evidence based guidance for infection prevention has been adopted such as Saving Lives and NATN/ICNA guidance

From the results in this survey it is evident that professionals work closely to both clinical guidelines published by organisations such as the National Association of Theatre Nurses or “*EPIC Project guidelines*” and DH policy such as “*Winning Ways*”.

However, given the findings from Question 8, it would be difficult to judge whether all practice met current updated guidelines.

c) All relevant Trust employees have adequate infection control training

The training of all relevant employees is a cornerstone of the Government’s drive to reduce the incidence of HCAIs across the UK’s health system. The need for training is confirmed in the “*Health Act 2006– Code of Practice for the Prevention and Control of Health Care Acquired Infections*” which states that all NHS organisations must include arrangements to ensure that “relevant staff, contractors and other persons whose normal duties are directly or indirectly concerned with patient care receive suitable and sufficient training, information and supervision on the measures required to prevent and control risks of infection.”

However, results from this survey show significant variance from these guidelines with **44% of**

respondents stating that not all relevant staff has had adequate training in the areas of infection control. It is a concern that some NHS organisations still do not have a system in place to adequately to train all necessary staff. One area on which to focus would be inductions by trusts for all new staff.

“Reviewing training programme to target key staff”

“No funds available within the Trust to attend or organise training days”

“NHS deficits too high in this Trust – won’t entertain training”

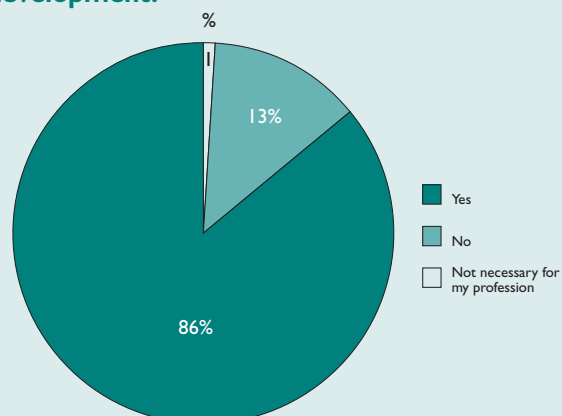
13. Agree?

Choice	Agree	%	Do not agree	%	Don't know	%	Total
Infection control leaders have been appointed at entry level	100	70	39	27	4	3	143
Evidence based guidance for infection prevention has been adopted	122	86	15	11	4	3	141
All relevant Trust employees have adequate infection control training	74	52	62	44	5	4	141

Question 14: Do you feel you have adequate access to training and development to keep up to date with the latest infection control practice?

Responses show that respondents themselves felt they had adequate access to information to keep themselves up to date (but very often felt that they did not have the time to read all the circulars and information they receive)

14. Adequate access to training and development?



There is little doubt that the majority of NHS organisations have invested heavily in an infection control prevention infrastructure, in line with Government guidance, and this has been reflected by the general reduction in cases of MRSA across England.

Whilst it is vital that key staff (predominantly senior clinical staff and trainers in this study) have access to training, it is also essential to regularly assess practice against guidelines through clinical audits. This is clearly not the case from the evidence of this survey.

“Not enough time for all desirable training”

“Difficult to change things as no money allocated”

“No funding to provide training”

Question 14b: If no, why not?

“Cost cutting for training of junior staff in the Infection Control Team”

“Limited due to lack of time money and resources”

“Access but not enough time to read all of it”

Question 15: For each of the following procedures, please tick which cutaneous/skin antiseptic (prep) is used for each relevant procedures.

Part of the Department of Health delivery programme to reduce healthcare associated infections is the commitment to reducing the number of infections in a sustainable manner which requires all parts of the organisations and all units, teams and wards to work together and focus on priority areas. The self assessment tools allow whole teams or units or entire organisations to consider key challenges that will support future actions towards improvement.

“The Five High Impact Interventions are simple evidence based tools that reinforce the practical actions that clinical staff need to undertake every time for key procedures in order to significantly reduce HCAI. Their aim is to increase the reliability of clinical processes and reduce unwarranted variation in care delivery.”

15. Cutaneous/skin antiseptics (prep) used for each procedure?

Choice	Alcohol only	Iodine-based	Chlorhexidine	None	Don't know
Percutaneous site insertions	61	11	44	1	17
Venous catheter insertions	45	22	62	0	14
Urinary catheter insertions	3	3	39	34	21
Blood gas collection	71	3	16	7	20
PICC line insertions	18	24	59	0	24
Haemodialysis catheter insertions	8	29	49	1	24
CAPD practices	5	18	39	1	32
Surgical incisions of all types	12	72	63	0	18

Question 16: Generally how satisfied are you with the current practices to reduce HCAs in your trust?

Importantly only 14% answering the survey were “**very satisfied**” with the infection control practices in their Trust. Given the professional standing of those who took part, this must be of concern to patients and the Patients Association, as well as to the Department.

Many of these participants should be in a position to directly influence the infection control practices of their Trust e.g. nurse directors, infection control staff and consultant. Whilst we can only surmise the reasons why these professionals are not totally happy with the practices in their organisation, the comments point to some likely answers:

“It is very difficult to change practices of some staff, there is always room for improvement, we are trying to work under incredible requests with little staff and no extra funding”

“Infection control practice is affected by a reduction in staff numbers and increases in workload v workforce”

“Pressure on capacity is a huge problem, we can't isolate”

“Would welcome patient/public campaign on what can be done to help”

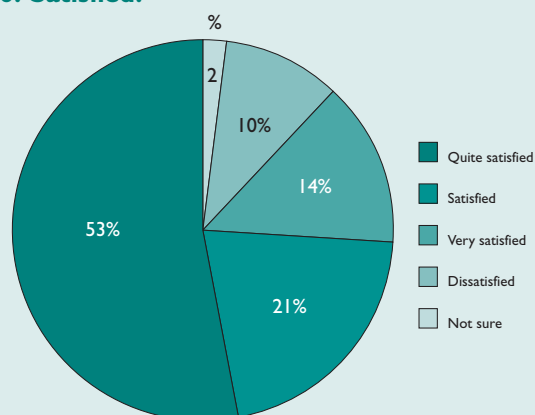
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“More work from the Patients Association and more campaigns to highlight this problem”

“Medical staff continue to disregard advice or do not seek advice from Infection Control Teams”

16. Satisfied?



Question 17. Your comments are invaluable, please feel free to include any information you think may help our study into aspects of infection control measures

“Due to financial constraints we have lost support and nursing time in our Infection Control Team due to staff leaving which will not be replaced”.

“How do we know what is priority – when targets dictate”

“Support to develop direct feedback to consultant / wards would be very helpful as would additional staff”

“The Patients Association 10 Top Tips available on every ward in every Trust”

“Pressure on capacity is a hugh problem”

“We have made tremendous strides, however we can never be complacent”

“Lack of funds, lack of autonomy in role”

“Always room for improvement”

“Staffing levels do have a direct impact on infection control practices”

Andy Burnham MP, Minister of State for Delivery and Quality at the Department of Health,

in a speech on the 9th May 2006 said

“To help tackle healthcare association infections, Trusts need a clear strategy for reducing infections – a strategy which is understood by all staff and implemented consistently”.

He acknowledged that the service is facing a tough year in balancing budgets – but he mentioned that “good hygiene and infection control is not additional but central to good financial management and housekeeping”.

This is the issue of the highest possible concern for the public and goes to the heart of the need to maintain public confidence in a clean, safe and reliable environment for the patients. The public expect their care will be in premises that are clean and hygienic, and that the treatment will be safe and reliable. These are the standards that the NHS must meet.

What are we going to do to prevent infection?

Every case needs to be treated as an adverse incident. The aim is to embed and sustain continuous improvement in quality of care. Any trust achieving its MRSA target reduction will save money and free up beds – but a trust driving down all infections to that level will, on average, save **£4 million and 6% of bed days.**

Healthcare acquired infections need to be at the top of the agenda when setting priorities and planning services across the board – environmental hygiene, staff training, cleaning contracts, bed management, and local clinical leadership. **ULTIMATELY LIVES CAN BE SAVED AND RESOURCES FREED UP FOR OTHER NEEDED SERVICES.**

Infection Control – Is it only skin deep?

Appendix

Appendix 11

“Additional comments”

We have very high levels of bed occupancy 99% so in many areas we are constantly at risk. We struggle we have to cancel operations and close wards. Can we reduce bed occupancy and resolve conflicting targets i.e. 4-hourly A&E wait?

I spend more time producing statistics than preventing infection. Activity for the infection control team has increased to breaking point.

Media coverage on healthcare associated infections has resulted in patients wanting to know if hospitals are clean and safe. Some patients refuse treatment in hospital due to fear of MRSA.

Very limited staff – we do the best we can.

Consideration is always given to cost – training given a very low priority – Trust has very high deficits.

We have used the Patients Association 10 point plan and have successfully restricted visiting times and no visitors are allowed to sit on patients beds.

Vast amounts of work going on into reducing hospital infection which is costing the health service millions of pounds. Why can't we get this right?

Infection Control is a critical area which we emphasise continuously – there is always more to be done. We thank the Patients Association for the fantastic work they as a voluntary organisation have done and continue to do.

More of our time is spent on counselling patients and relatives and sometimes staff. Trying to change staff practice is on going. Changing individual staff behaviour is one of our key targets and is the most challenging aspect of infection control.

The increased workload to deliver education and support has impacted on my clinical practice. For the provision of timely and appropriate information for patients who are concerned, we refer to the Patients Association web site for information for patients.

Getting clinical compliance is difficult but processes are in place.

I can't be absolutely confident that we are using the most effective skin antiseptic as the provision of recommended products varies. Some clinicians still prefer to use Betadene. This decision can still be influenced, dependent on practitioner use and whether or not it is user friendly.

When deciding on a skin preparation, a decision would be made on the product's efficacy, if there is more than one choice, cost decides.

Patients have a lack of confidence in the NHS - there is more responsibility for Infection Control although it has no extra funding or resources.

... how can I access my
medical records?

... I'm visiting my GP and
want some advice...

... how can I make a
complaint...

Call the The Patients Association Helpline

0845 608 44 55

The Patients Association is an advocacy group that highlights the concerns of patients. The Patients Association works with government and a broad range of individuals and organisations involved in healthcare to develop better and more responsive health services.

The Patients Association advocates for greater and equitable access to high quality, accurate and independent information for patients, for greater and equitable access to high quality care and for involvement in decision making as a right.

After 40 years The Patients Association still has a vital role to play. Our role is to help provide patients with the information that is difficult to access, often hidden away by vested interests. Our range of booklets help and so does our Helpline, but this is not enough. Over the coming months and years we aim to increase the amount

of information for patients so when we are offered a choice we know what we are choosing and why we are choosing it. The Patients Association is well placed as a platform to facilitate a dialogue between all the stakeholders in a patient's care, from the NHS itself to companies that produce the medical devices across to medical insurance companies and the pharmaceutical industry. The Patients Association is in a unique position, always challenging, always independent and always there for patients.

The Patients Association Helpline **0845 608 44 55** is there to help patients. It is a lo-call rate telephone number to help inform patients and gather their views.

We also have a range of booklets available for patients, including Living Wills – a guide for patients, How to make a complaint, You and your doctor, You and your dentist, How to access your medical records.

We have also produced a number of reports, including Infection Control & Medical Decontamination – a Survey of Strategic Health Authorities: Infection Control & Medical Devices and Tracking Medical Devices & the Implication for Patient Safety.

Booklets, reports and a lot more are available on our website
www.patients-association.com



listening to patients,
speaking up for change